CAMHD TECHNICAL REPORT NUMBER

Reliability and Congruence of Targets and Practices in Mental Health Assessments, Service Plans, and Treatment Plans

John Young, M.A.

Jason Schiffman, Ph.D.

Judy Lee, M.A.

Eric Daleiden, Ph.D.

Bruce F. Chorpita, Ph.D.

Charles Mueller, Ph.D.

Ryan Tolman, B.A.

Executive Summary and Recommendations

This report was generated through a collaborative effort between CAMHD's Research and Evaluation Program and the University of Hawai`i's Department of Psychology (UH). The two studies that comprised this effort both related to standard CAMHD treatment planning documents (Mental Health Assessments, Coordinated Service Plans, and Mental Health Treatment Plans). In the first study, the reliability of a new instrument for codifying psychotherapy in terms of specific targets and practice elements (the Service Guidance Review Form; SGRF) was tested using seven Family Guidance Center (FGC) Personnel and three Graduate Assistants from UH. The measure was based on earlier CAMHD coding systems, including the one used in the Evidence Based Services Committee (EBS) and the Monthly Treatment Progress Summaries (MTPS). The results of this study indicated that the SGRF was reliable in the contexts examined. This reliability was demonstrated at the level of a single rater, indicating that ongoing usage of the measure by a single trained rater is possible.

The second study used reliably coded data from the first study to examine rates of congruence between practice elements and targets recommended in one stage of treatment planning and subsequent stages. Data were analyzed in terms of how often codes were retained (recommended in both an initial and subsequent document) or dropped (recommended in an initial, but not subsequent, document). Results of this study indicated a low congruence between documents in all comparisons made. It seems that recommendations made in one stage of planning had little influence on subsequent stages of planning. This finding was particularly striking in an analysis of several severe targets (psychosis, runaway, safe environment, self-injurious behaviors, sexual misconduct, and

suicidality), which indicated that these codes in particular were generally dropped at a high rate between documents.

Several recommendations for modification to CAMHD's ongoing procedures can be made on the basis of these studies. First, it is recommended that several SGRF trained personnel regularly use this measure for ongoing quality assurance in the form of routine, random document review. Quality assurance efforts using the SGRF to look at congruence in treatment planning documents will provide information useful for establishing a benchmark, might improve congruence through the process of evaluation, and will allow for the testing of congruence improvement initiatives. Once ongoing record review using the SGRF is in place it is recommended that CAMHD compare the content of recommendations made at each stage of planning with content from what is known to be efficacious from empirical literature on treatment outcome. Coordination of this research with the EBS committee, which has coded a substantial amount of treatment outcome literature using a measure similar to the SGRF, will be essential in achieving this goal.

Finally, in terms of congruence improvement initiatives, it is recommended that subsequent studies be performed to determine the most effective and cost-efficient method of enhancing congruence in the treatment planning process. A specific study might be to train personnel from all FGCs on the usage of the SGRF and randomly select four FGCs to receive a brief treatment planning intervention in addition to this training. For the FGCs that receive the treatment planning intervention, completed MTPSs could be attached to each treatment planning document, enabling a shorthand summary of the document's recommendations. Providers responsible for subsequent stages of planning

could consult the MTPS for the previous document for information about specific techniques recommended, which may enhance congruence between stages. The other FGCs would receive each document as usual, without the benefit of the attached MTPS. All FGCs would code treatment planning documents using the SGRF at baseline and again after a suitable period (e.g., 6 months) of applying the intervention in randomly selected districts. Comparisons between the rate of congruence among service documents in the FGCs that received the intervention to those that did not would allow insight into the effect of the intervention.

The movement to inform practice regarding empirically supported psychological interventions has been well documented, particularly the identification of psychotherapies that have been demonstrated to be efficacious through randomized control trials (RCTs) (e.g., Chambless, Sanderson, Shoham, Johnson, Pope, Crits-Christoph, et al., 1996; Chambless, Baker, Baucom, Beutler, Calhoun, Crits-Christoph, et al., 1998; DeRubeis & Crits-Christoph, 1998). Alongside the support for this endeavor to integrate science into practice are criticisms regarding the clinical applicability of efficacy findings derived from RCTs (cf. Westen, Novotny, & Thompson-Brenner, 2004). Such criticisms commonly refer to the rigid structure and exclusive diagnosis-based packaging of empirically supported therapies (ESTs; for reviews and critiques see Beutler, 2002; Beutler & Baker, 1998; Bickman, 2002; Chambless & Ollendick, 2001; Eifert, Evans, & McKendrick, 1990; Luborsky, Rosenthal, Diguer, Andrusyna, Berman, Levitt, et al., 2002; Persons, 1991). The criticisms levied by many in the field collectively suggest that, while manualized therapies may serve as a methodological strength in RCTs, their feasibility may be limited in practice in front-line clinical settings.

Clinicians may be more likely to incorporate ESTs into their practice if efficacy associated with ESTs can be procured flexibly to meet diverse clinical needs, rather than following a prescribed treatment manual (cf. Kendall, Chu, Gifford, Hayes, & Nauta, 1998). Facilitating flexibility in practice might stem from translating EST manuals into individual techniques and processes appropriate for addressing commonly identified clinical targets. Without a reliable framework, however, clinical judgment, with all its inherent flaws and imprecision, may rule what is extracted and adapted from EST manuals. Subjective translations of manuals may provide the desired flexibility of use but

at the cost of their testability and replicability across settings, both core empirical features associated with ESTs. Alternatively, if techniques and processes are extracted from EST manuals into units that maintain their conceptual integrity and clinical efficacy, such efficacy might be clinically flexible and empirically testable. Employing a level of empirical analysis that can render ESTs into measurable and efficacious units of practice elements has the potential to systematically guide practice and practice research, and as such, may be the next wave of investigations warranted in the movement to promote the practice of evidence-based services.

Chorpita, Daleiden, and Weisz (2005) proposed the Distillation and Matching Model (DMM) to serve as a framework for this form of research. The DMM allows for the assessment of units of individual practice elements and targets of psychotherapeutic interventions (distillation), and investigation of their fit into real world practices depending upon a number of different variables (matching). The unique contribution of this model potentially allows for the translation of ESTs in manuals into clinically flexible units of practice elements, using a systematic rather than theoretical or intuitive approach. Accordingly, units derived from a tangible investigation based on the DMM might be used to examine common and unique treatment effects across a diverse range of clinical problems, regardless of their theoretical or structural fit with specific ESTs or clinical diagnosis. Empirical investigations using these units of practice elements, as opposed to entire manuals, might also be more conducive to generating practice-relevant findings and evaluating the integrity of such findings (e.g., psychometric evaluations). In short, the DMM as a methodological framework has the potential to address many of the

criticisms and limitations related to the rigidity of manualized ESTs, without sacrificing the empiricism necessary for rigorous scientific testing.

To date, CAMHD has applied the principles of the DMM to two separate, but related, coding endeavors. First, the feasibility and reliability of a coding system to distill psychosocial treatment outcome literature was examined in the context the Committee for Evidence Based Services (EBS). The EBS group performed a detailed literature review of extant psychosocial treatment outcome research for several areas of child and adolescent mental health, and the coding system was demonstrated to be reliable for the task (CAMHD, 2004). Second, this system was used to measure actual care through the development of a monthly treatment and progress summary report form (MTPS). Reliability tests in both of these studies indicated that the coding systems were reliable in the contexts that they were applied (CAMHD, 2004).

The current study represents a logical extension of this line of research to another common real world setting. The Service Guidance Review Form (SGRF), which is a new coding system based on the MTPS and EBS measure, was developed and applied to a record review of actual mental health assessments (MHA), coordinated services plans (CSP), and mental health treatment plans (MHTP). In mental health assessments, mental health professionals take measurements of an individual case, apply their knowledge of the research literature, and make recommendations regarding the focus of treatment and therapeutic practices to alleviate the youth's problems. This assessment information is then used in a multidisciplinary context to develop a comprehensive CSP, meant to be the guiding document within CAMHD to enable coordinated care. CSPs are used in conjunction with consumer preferences and provider specialties to construct

individualized MHTPs for treating particular youth. Thus, this examination of treatment planning documents (MHAs, CSPs, MHTPs) provides a key procedural link between the two other contexts (treatment outcome efficacy literature through EBS and actual care through the MTPS) in which a similar coding system has been applied.

The specific aim of the first study was to examine the interrater reliability among users of the coding system when applied to treatment planning documents records. A second study utilizing the reliably coded information from the first study examined the congruence of specific practice elements and targets between documents (that is, the degree to which recommendations made at one stage of planning carried over to subsequent treatment planning recommendations). Based on the preliminary reports of the reliability of the coding system mentioned above, it was hypothesized that adequate interrater reliability would be observed for the coding system. No specific hypotheses regarding congruence between documents were made, as this examination is the first of its kind in mental health research.

Method

Participants

Ten participants were recruited including seven participants from CAMHD's regional Family Guidance Centers (FGCs) and three graduate assistants (GAs) from the University of Hawaii at Manoa . CAMHD participants represented a wide range of diversity in terms of their level of education and professional status, including Quality Assurance Specialists, Mental Health Supervisors, a Clinical Psychologist, and a Branch Chief. The GA participants included two doctoral candidates in Clinical Psychology and one master's level student in Social Psychology.

Sample: Archival Data

Clinical charts of new admissions into the CAMHD system for Fiscal Year 2004 (FY04, which was the time period between July 1, 2003 and June 30, 2004, inclusive) were used. These charts each contained archived information, including the initial MHA along with related CSPs and MHTPs. Archived MHAs, CSPs and MHTPs for randomly selected cases (n = 200) initiated during FY04 were utilized. The total number of selected cases for each FGC was proportionate to its total population of registered youth for the study period, ranging from seven for Kauai FGC to 72 for Hawaii FGC. From the 200 cases, documents (MHAs, CSPs, and MHTPs) were selected for the final archival data sample.

Cases were included in the study if the charts contained the initial assessment that qualified the case for services (up to one year prior to intake) *and* at least one CSP or MHTP based on this initial assessment. During implementation, many of the cases were dropped due to unavailability of information in their records. Some of the missing information was due to record keeping errors, whereas others were discharged before complete service planning was performed. For example, some cases were registered for assessment of eligibility for the CAMHD Support for Emotional and Behavioral Development (SEBD) program and determined ineligible, so continued treatment planning was not performed. The resulting final sample of archival documents (n = 389) included 130 MHAs, 136 CSPs, and 113 MHTPs and was used to examine the inter-rater reliability among coders.

Randomization of documents. The order in which documents were to be coded was randomized to prevent potential confounds due to ordering effects. For example, it

was possible that coders could receive a packet of documents and decide to code them in a certain order; e.g., all the MHAs first. This could have introduced bias in their responses on the SGRF, given that the documents were formatted similarly and could have led to patterned responses on the instruments. Randomizing coding order eliminates this possible confound. Randomization was performed separately for each coder, such that no two coders for the same document would have been assigned identical documents previously.

Data related consent issues. Although these document sets are archival by some operational standards (e.g., post active clinical decision making stage, storage period of up to six months), MHAs and clinical charts, in general, contain personal information. Such personal information potentially could be used to identify individuals. In order to ensure protection of personal information and privacy as well as address related issues, the following measures were taken.

First, all participants or coders received individualized training on CAMHD policies and procedures specifically addressing the Health Insurance Portability and Accountability Act (HIPAA) and other confidentiality standards. In fact, all designated participants of the proposed study had already received this training prior to the study. As a safety measure, participants received a second training on privacy issues, collectively, reinforcing the importance of compliance with CAMHD privacy guidelines as they pertain specifically to the study.

Second, guidelines were implemented to address privacy issues that were specific to the features of the study. These were: (1) all documents and data sets remained at CAMHD throughout the study; (2) transportation and storage of identifiable personal

information followed standard CAMHD operating procedures including storage behind two physical barriers (e.g., locks); (3) GAs were not permitted to transport or store off-site any documents containing identifiable personal information; (4) all data management occurred on CAMHD premises and in accord with CAMHD procedures; (5) personally identifiable information was limited to that present in the archived documents; (6) GAs were provided with onsite supervision during the time when they had access to the personally identifiable information. Additionally, this research was carried out with the full approval of both the CAMHD and UH review boards.

Due to the archival nature of this study, informed consent for the specific project was not obtained from the individuals whose personal information was accessed. All individuals receiving services through CAMHD, however, review and sign the Notice of Privacy Practices (Appendix C) which informs consumers that their information may be used for the purpose of studies similar to the current project. All participant coders were orally briefed of their rights as research participants by the trainer at the beginning of each training session and a copy of the briefing was included in the training packet.

Study 1

Measures

Service Guidance Review Form (SGRF). The SGRF (Daleiden, Young, Schiffman, & Becker, 2005; Codebook in Appendix A; Instrument in Appendix B) is a review checklist constructed specifically for the study to identify specific practice elements and targets in treatment planning documents. The SGRF adopted relevant codes from the CAMHD Monthly Treatment and Progress Summary (MTPS) coding system and included additional contextual information. Three specific sections of the SGRF

were: 1) service allocation information and diagnostic impression; 2) clinical targets; and 3) practice elements. The SGRF was made available to coders in hardcopy and electronic versions. Participants or trained coders were asked to complete all three sections of the SGRF for each document coded.

Procedures

Training. The first portion of the training was on CAMHD policies and procedures regarding privacy issues, personally identifiable information, and their implications that are specific to the proposed study. Contents for this portion of the training have been outlined above.

The second portion of the training was on the usage of the SGRF. Prior to the training participants were provided with copies of the SGRF and related codebook, as well as rationale for their use and the focus of this project. Participants met for a half-day of training at the Diamond Head FGC. Initial training consisted of a brief review of the coding system and the project at large, and focused on the direct and practical application of this coding system to various scenarios depicting practice elements and targets. Examples utilized in these scenarios closely emulated formats typical of MHAs, CSPs, and MHTPs in an attempt to facilitate generalizability of skills obtained from this training to use of the SGRF. Training examples were created utilizing relevant documents from several cases from the previous fiscal year (FY03), which were fully redacted prior to implementation in training.

Pre-coding procedures. Two packets were sent out to each CAMHD participant as part of pre-coding procedures. The first packet consisted of a cover letter, an electronic version of a tracking sheet in a spreadsheet format that included a list of randomized

cases for their FGC, as well as the hardcopy of instructions for pre-coding procedures. Upon receiving packet one, participants were asked to locate case files specific to their FGC and make two sets of photocopies of relevant MHAs, CSPs, and MHTPs for each case. As they were making photocopies of each document, they were instructed to track this process by completing the three main items on the electronic tracking sheet: 1) number of each document copied; 2) the date of each document; and 3) the date photocopies were made for each document. Upon the completion of photocopying all relevant documents as well as completion of the tracking sheet, participants were instructed to send all photocopies of documents and their electronic tracking sheet (via floppy disk) to Diamond Head FGC via CAMHD's internal mail system following appropriate procedures for transporting confidential documents. Upon receiving copies of the documents and the tracking sheet disk from each FGC, GAs processed these documents for final sample selection by: 1) verification that each document met inclusion criteria; 2) assigning a unique identifier to each document; 3) completing and verifying tracking sheets.

The completed tracking sheets resulting from packet one were used for the second set of pre-coding procedures and the compilation of packet two. A GA at Diamond Head randomized the order of documents recorded in the tracking sheet to create packet two, which served as the coders' guide for the order in which to code documents. Packet two was unique for each individual coder, and was returned to them via CAMHD's standard procedures for transporting confidential materials.

Coding. All documents coded by each CAMHD coder were also coded by one GA coder. Throughout the coding process, all coders were provided with weekly follow-

up and check-in calls to track their coding progress. All coders were reminded of the time criteria by which to complete their coding.

Each CAMHD coder was instructed to code their portion of documents in the randomized order and not in the order of document numbers. To facilitate this process documents were returned to raters arranged in the order of the randomized list. All CAMHD coders used hardcopy versions of the SGRF only. Upon completion of their coding and tracking sheet two, CAMHD coders were instructed to make copies of all documents and code sheets for storage at their FGCs, then to transport documents, SGRFs, and tracking sheet two to CAMHD using appropriate transporting procedures described above. Data from completed SGRFs were then entered into a database. To ensure data accuracy, data were entered twice by separate people using separate files and were subsequently concatenated with all inconsistencies being investigated and resolved.

GA coders completed the coding procedure using an electronic version of the SGRF at the CAMHD site. GAs completed the coding process according to randomized order as described above for CAMHD coders. Each electronic entry of the SGRF was printed and filed with corresponding documents and archived for safe-keeping.

Statistical Analyses

In order to assess inter-rater reliability among coders, coded data was analyzed using Intraclass Correlations (Shrout & Fleiss, 1979). Adequate reliability of the instrument was defined as average ICC values of greater than .70 (model 2, 1) for each class of document (MHA, CSP, MHTP) considering both practice elements (PE) and targets (TAR) from the SGRF. This model uses a two-factor coding target by judge Analysis of Variance (ANOVA) framework and takes into account the coding target,

judge, and coding target by judge interaction. Additional sources of variation included in the model were FGC from which the case was selected and unique coder pairing teams. This model also estimates the reliability of a single judge rather than the mean of a team of judges. Although more conservative than multiple judge models, this condition is more in line with expectations in practice, where there is typically a single individual who reviews records.

Additionally, to assess whether or not a background in advanced clinical training affected the degree of reliability of the SGRF, a subset of documents for which both coders were clinical graduate students was compared. It was hypothesized that this condition would lead to a higher degree of reliability than the analysis considering all coders, given the expectation that these particular raters were more familiar with the empirical and clinically-oriented material that comprises the SGRF coding system.

Results

The ICC (2, 1 model, which determines reliability of the data at the level of a single judge) analysis regarding PE for all documents considered together yielded a value of 0.90, indicating a high level of reliability for the instrument across all document types coded by all raters. The same analysis applied to TAR yielded a value of 0.95, likewise indicating high reliability across all document types. Subsequent examination of ICC values for PE and TAR by document type yielded consistent results. For PEs, MHAs had a reliability value of 0.96; CSPs 0.81; and MHTPs 0.84. The same analysis of TAR reliability by document type also indicated a high level of reliability, with MHAs having an ICC (2, 1) of .85 and both CSPs and MHTPs having a value of 0.91.

The second set of ICC analyses was identical to the first, but included only those cases rated by both clinical psychology graduate students. The ICC (2, 1) for overall PE considering only these two raters was .85 and for TAR was .91. Analyses of PE by document type also indicated high reliability, with MHAs having a value of .89, CSPs .78, and MHTPs .81. The same analyses examining TAR by document type demonstrated a similar pattern, with MHAs exhibiting a reliability value of .90, CSPs .83, and MHTPs .89. These values, while high, were consistent with the analyses considering the overall pool of raters, and not supportive of the hypothesis that clinically trained raters would demonstrate higher reliability (see Table 1 for overall ICC results).

Table 1

Interclass correlations for Practice Elements and Treatment Targets by document type

	Practice Elements				**Treatment Targets**			
Raters	**Overall**	**MHA**	**CSP**	**MHTP**	**Overall**	**MHA**	**CSP**	**MHTP**
All raters	.90	.96	.81	.84	.95	.82	.91	.91
Clinical Graduate Student Raters Only	.85	.89	.78	.81	.91	.90	.83	.89

Note: MHA = Mental Health Assessment, CSP = Comprehensive Service Plan, MHTP = Mental Health Treatment Plan

Study 2

The results of the first study indicated a high degree of reliability between raters in all contexts examined using the SGRF instrument. A subsequent study was performed using this reliably coded data to assess the degree of congruence between specific practices and targets discerned at various stages of treatment. The structure of the data from the reliability study was such that there were two coders for each document, and thus two different and complete sets of data. Though the data were determined to be

highly reliable these two sets of data did not match one-to-one. This necessitated that the examination of congruence utilize *either* data produced by the graduate student raters or the diverse array of raters working in the FGCs and the first author of this study. The choice was made to use the data from the latter group of raters, as these were real-life representatives of the people working in the system of care examined.

Method

Procedure

Cases that contained at least two different types of treatment planning documents (MHA, CSP, MHTP) were selected for inclusion in this study. The treatment planning process is such that numerous MHTPs can be generated on the basis of a single CSP, as different providers may give care to the same child for different problems. As such, MHTP data was combined in those instances when a case had multiple MHTPs (i.e., if a given code appeared in any MHTP it was coded as present). Data were then compared pairwise by document type for congruence of specific treatment practices and targets across documents.

Statistical Tests

Data were compared between document types using conditional probabilities of occurrence of each target and practice code. This procedure led to three document comparisons: MHAs to CSPs (MHA-CSP; n = 122), CSPs to MHTPs (CSP-MHTP; n = 109) and MHAs to MHTPs (MHA-MHTP; n = 99). In addition to calculating conditional probabilities for all targets and practices, the base rate of occurrence of each code was also determined to provide context for the results. It was hypothesized that lower base rate codes might be less likely to appear in subsequent documents.

Kappa statistics were also calculated in association with each probability. This was in an effort to help determine whether or not the results of any congruence analysis were due to factors other than chance agreement or disagreement. A significant Kappa value associated with a particular code indicates that identified in/congruities are likely not due to chance alone.

Structuring of Reporting

Conditional probability analyses produced four basic pieces of information. A code could be present in both documents (congruent present), absent in both documents (congruent absent), present in the first document of the sequence but absent in the second (incongruent absent) or absent in the first document in the sequence and present in the later document (incongruent present). Documents were analyzed from the perspective of their temporal sequence in the treatment planning process such that it was clear in all comparisons which document came first (MHA-CSP-MHTP).

Of most theoretical interest were the congruent present (hereafter referred to as *retained*) and incongruent absent distinctions (hereafter referred to as *dropped*). Analysis of these conditional probabilities gives an indication of the amount of guidance one stage of treatment planning takes from prior stages. In theory, most or all recommendations from MHAs should be incorporated into CSPs. Similarly, most or all practice elements and treatment targets identified in CSPs should appear in later MHTPs.

In a system of care designed to address clients' comprehensive service needs it is expected that the congruence between each of these documents should be high. That said, this is the first study of its kind, and no empirical benchmark could be found regarding what to expect in terms of the retention or dropping of specific codes across stages of

treatment planning. As such, a rationally defined criteria of .50 was established as a comparison value. This value is liberal in terms of congruence between treatment planning stages, but was seen as an appropriate set point for this examination. If overall congruence averages did not approach at least 50%, then it seems reasonable to argue that documents produced at any one point were not drawing strong guidance from those produced in the relevant previous stages.

Results

Comparisons of overall averages to the .50 criteria by document type appear in Table 2. All comparisons for both targets and practice elements across all documents were significantly lower than this criterion, indicating a low degree of congruence throughout the treatment planning process.

Table 2

Average congruence of all codes between documents

	Proportion of overall congruence	
	Targets	Practice Elements
Document Comparison		
MHA-CSP	0.35*	0.34*
CSP-MHTP	0.44*	0.35*
MHA-MHTP	0.37*	0.30*

*p < .01 (difference from .50)

Note: MHA = Mental Health Assessment, CSP = Comprehensive Service Plan, MHTP = Mental Health Treatment Plan

Table 3 contains the most retained and dropped codes by document type comparison with two criteria for reporting (see Tables 4 and 5 for base rates and proportion dropped for all codes). First, the base rate of the code in the initial document in the treatment planning sequence had to be at least .10 (i.e., endorsed in at least 10% of

documents). Second, the rate of being either retained or dropped had to exceed .50, (50%). These criteria were set in an effort to hone in on those that were both present at substantial levels and highly retained or dropped between documents. There were numerous treatment targets that fulfilled both of these criteria; as such, only the top 5 for each category were reported here. The practice elements reported, however, represent an exhaustive list, as few codes fulfilled these criteria.

Generally speaking, targets related to substance abuse, educational engagement, and oppositional behavior were retained at the highest level seen in this study. Targets regarding internalizing problems (e.g., anxiety and depression), on the other hand, were often dropped at high rates. For practice elements, communication skills along with cognitive and family therapy techniques were the most retained codes. Frequently dropped practice elements included peer modeling/pairing, anger management, and several codes typically tied to the treatment of internalizing disorders (e.g., psychoeducation with child, activity scheduling, self-monitoring, and relaxation).

Table 6 presents information concerning extremely difficult problem areas without regard for base rate. These codes are some of the most problematic targets of treatment, both in terms of resources typically expended and potential for human suffering. These codes included psychosis, runaway, safe environment, self-injurious behaviors, sexual misconduct, and suicidality. In all cases base rates of these targets were low (see Table 5), but given the severity of difficulty it was expected that these targets would be highly congruent across documents. As can be seen in this table, these problematic targets were generally dropped at a high rate across documents, with the exception of psychosis between CSPs and MHTPs. (See following pages for tables 3-6.)

Table 3

Most retained/dropped codes by document comparisons

MHA-CSP (n = 122)		CSP-MHTP (n = 109)		MHA-MHTP (n = 99)	
Most Retained Targets:					
Substance Use	0.76*	Substance Use	0.83*	Substance Use	0.80
School Refusal/Truancy	0.74*	Positive Family Functioning	0.73*	Positive Family Functioning	0.72
Academic Achievement	0.70	Oppositional/Non-Compliant Behavior	0.62	Oppositional/Non-Compliant Behavior	0.68
Oppositional/Non-Compliant Behavior	0.64*	School Refusal/Truancy	0.61*	School Refusal/Truancy	0.65
Positive Peer Interaction	0.53	Academic Achievement	0.60	Academic Achievement	0.56
Most Retained Practice Elements:					
Cognitive/Coping	0.75*	Family Therapy	0.58	Family Therapy	0.52
Counseling	0.56	Cognitive/Coping	0.56	Cognitive/Coping	0.50
Educational Support	0.51	Twelve-step Programming	0.54*	Communication Skills	0.50
		Communication Skills	0.52		
Most Dropped Targets:					
Low Self-Esteem	0.88	Peer Involvement	1.00	Treatment Planning/Framing	1.00
Attention Problems	0.86	Activity Involvement	0.88	Anxiety	0.81
Depressed Mood	0.79*	Low Self-Esteem	0.80	Activity Involvement	0.77
Anxiety	0.77*	Community Involvement	0.73	Depressed Mood	0.77
Activity Involvement	0.77	Information Gathering	0.70	Attention Problems	0.76
Most Dropped Practice Elements:					
Peer Modeling/Pairing	0.85	Self-Monitoring	0.83	Peer Modeling/Pairing	0.82
Parenting	0.83	Antecedent Management	0.83	Anger Management	0.80
Psychoeducation - Child	0.83	Care Coordination	0.77	Medication/Pharmacotherapy	0.78
Activity Scheduling	0.79	Parent Praise	0.77	Educational Support	0.73
Anger Management	0.78	Relaxation	0.77	Activity Scheduling	0.71

Note: All included codes had at least a .10 base rate in the initial document of the series and a .50 rate of being retained or dropped

* = Kappa was significant at .05 level

Table 4

Base rates and proportion dropped for Practice Elements

Treatment Practice	Base Rate in MHA	Base rate in CSP	Dropped between MHA-CSP	Base Rate in CSP	Base Rate in MHTP	Dropped between CSP-MHTP	Base Rate in MHA	Base Rate in MHTP	Dropped between MHA-MHTP
Activity Scheduling	0.20	0.29	0.79	0.29	0.25	0.66	0.21	0.26	0.71
Anger Management	0.15	0.21	0.78	0.23	0.26	0.52*	0.15	0.24	0.80
Animal or Plant Assisted Activities	0.00	0.00	N/A	0.00	0.05	N/A	0.00	0.05	N/A
Arousal Reconditioning	0.00	0.00	N/A	0.00	0.00	N/A	0.00	0.00	N/A
Art/Music Therapy	0.00	0.02	N/A	0.02	0.02	1.00	0.00	0.03	N/A
Assertiveness Training	0.02	0.08	1.00	0.07	0.15	0.50*	0.02	0.17	1.00
Assessment	0.41	0.37	0.56	0.36	0.27	0.69	0.41	0.27	0.63
Behavior Management	0.18	0.20	0.77	0.20	0.26	0.73	0.16	0.26	0.63
Behavioral Contracting	0.06	0.13	0.86	0.13	0.25	0.57	0.06	0.26	0.33
Biofeedback/Neurofeedback	0.00	0.00	N/A	0.00	0.03	N/A	0.00	0.02	N/A
Care Coordination	0.08	0.18	0.60	0.20	0.14	0.77	0.09	0.14	0.89
Catharsis	0.01	0.00	1.00	0.00	0.02	N/A	0.00	0.03	N/A
Cognitive/Coping	0.20	0.52	0.25*	0.54	0.50	0.39	0.20	0.50	0.45
Commands/Limit Setting	0.07	0.11	0.88	0.11	0.18	0.58*	0.08	0.18	0.88
Communication Skills	0.11	0.38	0.54	0.39	0.44	0.40	0.10	0.46	0.40
Counseling	0.52	0.52	0.44	0.51	0.43	0.61	0.52	0.45	0.53
Crisis Management	0.03	0.02	1.00	0.03	0.08	1.00	0.02	0.09	1.00
Cultural Training	0.00	0.00	N/A	0.01	0.01	1.00	0.00	0.01	N/A
Directed Play	0.00	0.00	N/A	0.00	0.01	N/A	0.00	0.01	N/A
Educational Support	0.45	0.52	0.49	0.52	0.26	0.65	0.44	0.29	0.73
Emotional Processing	0.02	0.00	1.00	0.00	0.06	N/A	0.01	0.06	1.00
Exposure	0.01	0.01	1.00	0.00	0.02	N/A	0.01	0.02	0.00*
Eye Movement/Body Tapping	0.00	0.00	N/A	0.00	0.00	N/A	0.00	0.00	N/A
Family Engagement	0.02	0.06	1.00	0.06	0.08	0.83	0.02	0.09	1.00
Family Therapy	0.42	0.34	0.67	0.30	0.47	0.42	0.44	0.49	0.45

Treatment Practice	Base Rate in MHA	Base rate in CSP	Dropped between MHA-CSP	Base Rate in CSP	Base Rate in MHTP	Dropped between CSP-MHTP	Base Rate in MHA	Base Rate in MHTP	Dropped between MHA-MHTP
Family Visit	0.02	0.10	1.00	0.09	0.10	0.60*	0.02	0.11	1.00
Free Association	0.00	0.00	N/A	0.00	0.00	N/A	0.00	0.00	N/A
Functional Analysis	0.03	0.03	1.00	0.05	0.06	1.00	0.03	0.06	0.67*
Goal Setting	0.03	0.06	1.00	0.06	0.07	0.86	0.04	0.07	1.00
Guided Imagery	0.00	0.01	N/A	0.01	0.03	1.00	0.00	0.03	N/A
Ho'Oponopono	0.00	0.00	N/A	0.00	0.00	N/A	0.00	0.00	N/A
Hypnosis	0.00	0.00	N/A	0.00	0.00	N/A	0.00	0.00	N/A
Ignoring or DRO	0.00	0.00	N/A	0.00	0.01	N/A	0.00	0.01	N/A
Informal Supports	0.09	0.16	0.55*	0.16	0.09	0.76*	0.08	0.11	1.00
Insight Building	0.05	0.12	0.83	0.13	0.28	0.71	0.05	0.31	0.40
Interpretation	0.00	0.00	N/A	0.00	0.00	N/A	0.00	0.00	N/A
Juvenile Sex Offender Treatment	0.00	0.00	N/A	0.00	0.00	N/A	0.00	0.00	N/A
Legal Assistance/Involvement	0.07	0.16	0.67	0.17	0.20	0.58*	0.09	0.21	0.44*
Line of Sight Supervision	0.00	0.01	N/A	0.01	0.02	1.00	0.00	0.02	N/A
Maintenance/Relapse Prevention	0.05	0.07	0.83	0.07	0.13	0.88	0.04	0.15	1.00
Marital Therapy	0.00	0.01	N/A	0.01	0.02	1.00	0.00	0.01	N/A
Medication/Pharmacotherapy	0.46	0.25	0.61*	0.26	0.16	0.68*	0.41	0.17	0.78
Mentoring	0.03	0.01	1.00	0.02	0.07	1.00	0.02	0.07	0.50*
Milieu Therapy	0.06	0.03	0.86	0.04	0.08	0.75	0.06	0.08	1.00
Mindfulness	0.00	0.00	N/A	0.00	0.03	N/A	0.00	0.02	N/A
Modeling	0.02	0.19	1.00	0.18	0.15	0.65	0.02	0.15	1.00
Motivational Interviewing	0.00	0.00	N/A	0.00	0.03	N/A	0.00	0.03	N/A
Natural and Logical Consequences	0.07	0.25	0.78	0.24	0.26	0.69	0.08	0.27	0.75
Parent Coping	0.01	0.03	1.00	0.04	0.08	1.00	0.01	0.08	1.00
Parent Praise	0.02	0.13	1.00	0.12	0.21	0.77	0.03	0.21	0.67
Parenting	0.10	0.12	0.83	0.11	0.12	0.58*	0.09	0.12	0.89*
Parent-Monitoring	0.05	0.16	0.83	0.18	0.28	0.55	0.04	0.29	0.25*
Peer Modeling/Pairing	0.11	0.11	0.85	0.08	0.11	0.67*	0.11	0.12	0.82
Play Therapy	0.03	0.02	1.00	0.02	0.05	1.00	0.03	0.05	0.33
Problem Solving	0.12	0.17	0.73	0.15	0.24	0.69	0.12	0.22	0.67

Treatment Practice	Base Rate in MHA	Base rate in CSP	Dropped between MHA-CSP	Base Rate in CSP	Base Rate in MHTP	Dropped between CSP-MHTP	Base Rate in MHA	Base Rate in MHTP	Dropped between MHA-MHTP
Psychoeducation - Child	0.10	0.11	0.83	0.09	0.10	0.80	0.10	0.11	0.90
Psychoeducation - Parent	0.07	0.07	1.00	0.09	0.08	0.90	0.08	0.08	0.88
Relationship/Rapport Building	0.01	0.02	1.00	0.01	0.10	1.00	0.01	0.12	1.00
Relaxation	0.05	0.14	0.83	0.12	0.13	0.77	0.05	0.12	0.80
Response Cost	0.01	0.02	0.00*	0.03	0.08	0.33*	0.01	0.08	0.00*
Response Prevention	0.01	0.02	1.00	0.01	0.04	1.00	0.01	0.04	1.00
Self-Monitoring	0.05	0.12	0.50*	0.11	0.18	0.83	0.05	0.19	0.60
Self-Reward/Self-Praise	0.00	0.01	N/A	0.01	0.03	1.00	0.00	0.03	N/A
Skill Building	0.03	0.08	1.00	0.09	0.12	0.80	0.04	0.12	1.00
Social Skills Training	0.10	0.17	0.75	0.18	0.36	0.50	0.10	0.35	0.50
Stimulus Control/Antecedent Management	0.07	0.15	0.89	0.17	0.15	0.83	0.08	0.15	0.63
Supportive Listening/Client-Centered Therapy	0.02	0.02	1.00	0.01	0.03	1.00	0.01	0.04	1.00
Tangible Rewards	0.05	0.25	0.50	0.26	0.38	0.57	0.05	0.37	0.40
Therapist Praise/Rewards	0.00	0.06	N/A	0.08	0.08	0.89	0.00	0.08	N/A
Thought Field Therapy	0.00	0.00	N/A	0.00	0.00	N/A	0.00	0.00	N/A
Time Out	0.01	0.05	1.00	0.06	0.08	0.50*	0.01	0.09	1.00
Twelve-step Programming	0.09	0.11	0.82	0.12	0.13	0.46*	0.10	0.14	0.60*

Note: Base rates differ across document comparisons due to a different number of documents comprising each analysis.
*p < .05 for Kappa

Table 5

Base rates and proportion dropped for Targets

Treatment Target	Base Rate in MHA	Base rate in CSP	Dropped between MHA-CSP	Base Rate in CSP	Base Rate in MHTP	Dropped between CSP-MHTP	Base Rate in MHA	Base Rate in MHTP	Dropped between MHA-MHTP
Academic Achievement	0.47	0.66	0.30	0.71	0.60	0.39	0.48	0.60	0.42
Activity Involvement	0.11	0.24	0.77	0.24	0.20	0.88	0.13	0.21	0.77
Adaptive Behavior/Living Skills	0.07	0.07	0.89	0.06	0.09	0.57*	0.09	0.09	0.78
Adjustment to Change	0.02	0.03	1.00	0.04	0.04	0.50*	0.01	0.03	1.00
Adult Intercoordination	0.1	0.2	0.75	0.22	0.27	0.54	0.12	0.29	0.58
Aggression	0.11	0.12	0.71*	0.14	0.25	0.60	0.11	0.26	0.64
Anger	0.21	0.38	0.65	0.37	0.42	0.45	0.22	0.40	0.59
Anxiety	0.18	0.09	0.77*	0.09	0.06	0.50*	0.16	0.06	0.81
Assertiveness	0.02	0.11	1.00	0.09	0.14	0.60*	0.02	0.15	1.00
Attention Problems	0.24	0.09	0.86	0.11	0.16	0.67	0.21	0.15	0.76
Avoidance	0.01	0.02	1.00	0.02	0.04	1.00	0.01	0.04	1.00
Caregiver Self-Management/Coping	0.02	0	1.00	0.00	0.06	N/A	0.01	0.05	1.00
Cognitive-Intellectual Functioning	0.01	0.02	1.00	0.02	0.00	1.00	0.01	0.00	1.00
Community Involvement	0.07	0.12	0.78	0.14	0.15	0.73	0.06	0.15	1.00
Compulsive Behavior	0.01	0	1.00	0.00	0.00	N/A	0.01	0.00	1.00
Contentment, Enjoyment, Happiness	0.01	0.02	1.00	0.02	0.03	1.00	0.01	0.03	0.00*
Depressed Mood	0.34	0.11	0.79*	0.11	0.20	0.50*	0.30	0.20	0.77
Eating, Feeding Problems	0.01	0	1.00	0.01	0.03	1.00	0.00	0.03	N/A
Empathy	0.02	0.02	1.00	0.02	0.09	0.00*	0.02	0.08	1.00
Enuresis, Encopresis	0.01	0.01	1.00	0.01	0.01	0.00*	0.01	0.01	1.00
Fire Setting	0	0	N/A	0.00	0.00	N/A	0.00	0.00	N/A
Gender Identity Problems	0	0	N/A	0.00	0.00	N/A	0.00	0.00	N/A
Goal Setting	0.02	0.04	0.67*	0.04	0.06	1.00	0.03	0.06	0.67*
Grief	0.03	0.02	1.00	0.03	0.06	0.67*	0.03	0.06	0.67*
Health Management	0.03	0.05	1.00	0.06	0.03	0.83*	0.03	0.01	1.00

Treatment Target	Base Rate in MHA	Base rate in CSP	Dropped between MHA-CSP	Base Rate in CSP	Base Rate in MHTP	Dropped between CSP-MHTP	Base Rate in MHA	Base Rate in MHTP	Dropped between MHA-MHTP
Housing/Living Situation	0.07	0.07	0.88	0.07	0.06	0.88	0.07	0.06	0.71*
Hyperactivity	0.07	0.01	1.00	0.01	0.03	1.00	0.05	0.02	1.00
Information Gathering	0.39	0.34	0.54*	0.34	0.24	0.70	0.40	0.21	0.70
Learning Disorder, Underachievement	0.02	0.01	1.00	0.01	0.01	1.00	0.02	0.01	1.00
Low Self-Esteem	0.13	0.16	0.88	0.18	0.26	0.80	0.11	0.29	0.64
Mania	0	0	N/A	0.00	0.00	N/A	0.00	0.00	N/A
Medical Regimen Adherence	0.28	0.22	0.59*	0.20	0.12	0.64*	0.25	0.13	0.72*
Occupational Functioning/Stress	0.02	0.05	1.00	0.07	0.07	0.88	0.03	0.07	0.67
Oppositional/Non-Compliant Behavior	0.23	0.45	0.36*	0.41	0.55	0.38	0.22	0.58	0.27
Parenting Skills	0.1	0.11	0.83	0.12	0.19	0.46*	0.11	0.18	0.64
Peer Involvement	0.07	0.11	1.00	0.10	0.13	1.00	0.07	0.14	0.57
Peer/Sibling Conflict	0.06	0.07	0.86	0.08	0.06	1.00	0.06	0.06	1.00
Personal Hygiene	0	0.01	N/A	0.01	0.00	1.00	0.00	0.00	N/A
Phobia/Fears	0.02	0	1.00	0.00	0.01	N/A	0.03	0.02	1.00
Positive Family Functioning	0.3	0.44	0.47	0.47	0.59	0.22*	0.29	0.63	0.24
Positive Peer Interaction	0.14	0.37	0.47	0.39	0.50	0.35*	0.13	0.54	0.46
Positive Thinking/Attitude	0.05	0.03	1.00	0.05	0.10	1.00	0.04	0.12	0.75
Pregnancy Education/Adjustment	0	0	N/A	0.00	0.00	N/A	0.00	0.00	N/A
Psychosis	0.04	0	1.00	0.00	0.01	N/A	0.03	0.01	0.67*
Runaway	0.08	0.07	0.80	0.09	0.17	0.60*	0.09	0.18	0.44*
Safe Environment	0.05	0.09	0.83	0.11	0.04	1.00	0.06	0.04	1.00
School Involvement	0.02	0.07	1.00	0.07	0.05	0.88	0.01	0.05	1.00
School Refusal/Truancy	0.16	0.42	0.26*	0.42	0.42	0.39*	0.17	0.43	0.35*
Self-Injurious Behavior	0.04	0.05	0.80	0.06	0.06	0.83	0.03	0.08	0.67
Self-Management/Self-Control	0.16	0.36	0.47	0.36	0.41	0.46	0.16	0.41	0.56
Sexual Misconduct	0.02	0.01	0.67*	0.01	0.01	1.00	0.03	0.01	0.67*
Sexual Orientation	0	0	N/A	0.00	0.00	N/A	0.00	0.00	N/A
Shyness	0	0.01	N/A	0.01	0.00	1.00	0.00	0.00	N/A

Treatment Target	Base Rate in MHA	Base rate in CSP	Dropped between MHA-CSP	Base Rate in CSP	Base Rate in MHTP	Dropped between CSP-MHTP	Base Rate in MHA	Base Rate in MHTP	Dropped between MHA-MHTP
Sleep Disturbance	0.01	0.01	1.00	0.01	0.01	1.00	0.00	0.01	N/A
Social Skills	0.11	0.29	0.62	0.31	0.42	0.44	0.10	0.40	0.50
Speech and Language Problems	0.02	0	1.00	0.00	0.01	N/A	0.02	0.01	1.00
Substance Use	0.34	0.4	0.24*	0.39	0.46	0.17*	0.35	0.47	0.20*
Suicidality	0.06	0.04	0.86	0.04	0.03	0.75*	0.06	0.04	0.83
Traumatic Stress	0.07	0.03	1.00	0.04	0.06	1.00	0.07	0.06	0.57*
Treatment Engagement	0.02	0.06	1.00	0.05	0.06	1.00	0.02	0.06	1.00
Treatment Planning/Framing	0.09	0.1	1.00	0.11	0.08	0.67*	0.11	0.08	1.00
Willful Misconduct, Delinquency	0.19	0.09	0.83	0.09	0.17	0.90	0.19	0.16	0.74

Note: Base rates differ across document comparisons due to a different number of documents comprising each analysis.
*p < .05 for Kappa

Table 6

Problematic target codes

	Probability of being dropped between documents (base rate in initial document)		
	MHA-CSP (n = 122)	**CSP-MHTP (n = 109)**	**MHA-MHTP (n = 99)**
Targets of interest			
Psychosis	1.00 (.04)	0.00 (.01)	.67 (.03)
Runaway	0.80 (.08)	.60 (.09)	.44 (.09)
Safe Environment	.83 (.05)	1.00 (.11)	1.00 (.06)
Self-Injurious Behaviors	0.80 (.04)	.83 (.06)	.67 (.03)
Sexual misconduct	.67 (.02)	1.00 (.01)	.67 (.03)
Suicidality	.86 (.06)	.75 (.04)	.83 (.06)

Note: MHA = Mental Health Assessment, CSP = Comprehensive Service Plan, MHTP = Mental Health Treatment Plan

Discussion

The first main finding from the first study was that the SGRF coding system can be reliably applied to treatment planning documents using a diversity of raters in terms of educational background, familiarity with principles and practices of clinical psychology, and years of experience in CAMHD positions. The level of reliability demonstrated considering all raters was approximately equivalent to highly and similarly trained raters who specialized in clinical psychology. For ongoing use of the system, the data from this study would seem to support the utility of using a single rater, as ICC scores were in the high range considering a single judge from this pool of raters. Additionally, coders who were psychology graduate students had comparable reliability relative to CAMHD employees. This finding suggests that the SGRF can be used reliably by people with different training and experiences. In short, it would seem that training in the use of the SGRF as applied to treatment planning documents was sufficient to produce highly reliable and potentially useful coding on this instrument.

The second main finding was from Study 2, which indicated a low degree of overall congruence between documents. Many specific practice elements were retained less than 50% of the time across treatment planning stages (see Tables 2 and 3). This suggests that specific aspects of treatment stated at any one stage of planning, particularly as related to practice elements, did not strongly influence subsequent stages of planning. To put it another way, it seems that recommendations made in a child's initial assessment often do not find their way into treatment plans for the same child. This finding is essential to ongoing efforts of service improvement within CAMHD, as many resources are expended in providing children with CASSP (Stroul & Friedman, 1986) consistent assessments upon intake. To the extent that recommendations produced from these resource-intensive documents are of a high quality, it follows that CAMHD would want to make use of them throughout the treatment planning process. The present data suggest this is not occurring , and signal a problem with consistency of care coordination across multiple domains, itself a prominent CASSP principle.

Further information is available by examining the composition of codes that were most/least likely to be retained (Table 3). Across all examinations the target of substance use had the highest rate of retention, and in all cases this was supported by a significant Kappa value (indicating that it was not likely to be due to chance). Other highly retained target codes related to oppositional behavior, school attendance, and academic achievement, while targets related to internalizing problems were generally among the most dropped. Collectively, these findings suggest that the system has a higher proportion of retention of target codes from externalizing domains, which is consistent with the population most serviced in CAMHD. It is conceivable that externalizing problems are

more salient to all members of the team responsible for the creation of these documents, and are thus retained at a higher level. On the other hand, it is possible that internalizing problems that are likely to be less overt or environmentally disruptive might be viewed differently and/or overlooked by various members of the treatment teams, thus perhaps contributing to a lower degree of retention.

Examination of practice elements did not produce as much consistency or data relevant to thematic content, as the most retained elements of cognitive and family techniques could be usefully directed toward a number of problems. The lists of most-dropped practice elements did provide one interesting standout at the CSP-MHTP stage of analysis, however. Care coordination, ostensibly one of the primary functions of a system of care, was among the most-dropped codes, with 77% of recommendations at the CSP stage being absent from the subsequent MHTPs.

Finally, analysis of the problematic codes information (Table 6) indicated some significant lack of consistency across stages of planning. These targets were theoretically representative of some of the most severe and/or potentially dangerous problems children could experience, yet in almost all cases the rate of these codes being dropped across documents was very high. Of particular note among these codes was the target of suicidality: a 4% base rate for this code in the MHA-CSP analysis indicated that approximately 5 children (100% of this low base rate group) had a recommendation regarding suicide in their assessments that was not picked up in their CSP. The cost to these children, families, and the entire CAMHD network of invested service providers of missing or ignoring these problems when present is extremely high, and the findings of this study make salient the fact that this is occurring with some frequency and

consistency. Future work would do well to enhance treatment planning teams' attention to congruence for all codes examined, but particularly those that are irreversible and likely to result in a high cost of human suffering.

Limitations

The primary limitation of these studies was the use of multiple diverse coders. The use of only two coders would have allowed for quicker data collection and easier data management, decreased the need for complicated interactions in the statistical ICC analyses, and reduced some other potential confounds. Ultimately, a two-rater approach would have given more standardization to these studies and allowed a fairer test of the system, which could have more closely informed revision and subsequent usage. Given the high degree of reliability demonstrated in Study 1 this is likely a secondary point, but one that bears mention as the setup for the current study was decidedly constrained by virtue of its being performed in a front-line, fast-paced setting.

Additionally, it is important to note that a lack of congruence as demonstrated in the second study does not necessarily equate to a lack of outcome as measured by various standardized instruments within CAMHD over time. It is possible that these cases showed improvement over time and that the lack of congruence between treatment planning documents had little or no deleterious effects. Without prior research regarding congruence expectations and/or an examination of outcomes, this possibility represents a potential confound to the congruence study's findings.

Future Directions

An interesting subsequent study might compare the content of treatment planning documents to evidence-based practices illustrated in psychosocial treatment outcome

literature. Composite practice element profiles of this literature exist through the EBS committee's coding efforts (EBS, 2004) which would allow for such comparisons. In this way it would be possible to determine if treatment practices recommended are consistent with the best available scientific research knowledge. Additionally, to the extent that evidence-based practices are or are not recommended in treatment settings, comparisons at each stage of planning (MHA, CSP, MHTP) would allow for an analysis of the nature of science in practice, and could inform efforts to determine barriers that exist in this implementation. If, for example, it was found that evidence-based practice tends to break down at the MHTP stage, rather than the MHA or CSP stage, then examination of this document across the system might be warranted.

In regard to findings from the second study, it would be very useful to identify methods for increasing the effect of one stage of treatment planning has on subsequent stages. There are many strategies for improving congruence across these events, and one of the most simple would make for an interesting initial study. Most practitioners within CAMHD are familiar with the MTPS sheets as they complete them for all treatment cases each month. It would be possible, in randomized fashion by FGC, to require each treatment planning document to be issued with a completed MTPS summary sheet describing recommended targets and practices. This would enable clear, efficient communication of specific codes across treatment planning stages. It would also likely permeate the way professionals think about the cases within CAMHD, which would enhance their ability to extract specific targets and practices from treatment planning documents. If an innovation such as this is implemented in broad fashion, expectations based on diffusion research would predict that it will influence informal communication

and eventually become the standard method of dealing with these issues (Rogers, 2003). RCTs testing this idea and standard system of care quality improvement studies done over time could lead to valuable discoveries in terms of a potentially fast, efficient and inexpensive method of increasing congruence.

Longer-term research is also possible in comparison of treatment planning documents to actual practice. One source of data for this form of analysis is the previously mentioned MTPS reports. Another source of data, which would take more time and resources to procure, are video or audio taping actual therapy sessions and coding for SGRF content. Once reliably codified, this would offer a more direct and substantial basis of comparison for treatment planning, which could then be compared to MHTP data and MTPS data for reliability.

Collectively, any or all of these studies may serve to enhance care for the children of Hawaii and potentially influence other systems of care to adopt similar research programs and ongoing methods of quality assurance. These studies demonstrated the reliability of this coding system, identified a lack of congruence across planning domains, and outlined a unique approach to understanding treatment planning. While this methodology is innovative and potentially exciting to many researchers and practitioners in systems of care, these are but the first steps in a host of possible research studies that could help improve treatment planning and service delivery.

References

Beutler, L. E. (2002). The dodo bird is extinct. *Clinical Psychology: Science and Practice*, *9,* 30-34.

Beutler, L.E., & Baker, M. (1998). The movement toward empirical validation: At what level would we analyze, and who are the consumers? In K.S. Dobson & K.D. Craig (Eds.) *Empirically supported therapies: Best practice in professional psychology (pp.43-65).* Thousand Oaks, CA: Sage Publications.

Bickman, L. (2002). The death of treatment as usual: An excellent first step on a long road. *Clinical Psychology: Science and Practice, 9,* 195-199.

Chambless, D.L., Baker, M.J., Baucom, D.H., Beutler, L.E., Calhoun, K.S., Crits-Cristoph, P., Daiuto, A., DeRubeis, R., Detweiler, J., Haaga, D.A.F., Bennett Johnson, S., McCurry, S., Mueser, K.T., Pope, K.S., Sanderson, W.C., Shoham, V., Stickle, T., Williams, D.A., & Woody, S. (1998). Update on empirically validated therapies: II. *The Clinical Psychologist, 51,* 3-16.

Chambless, D. L., Sanderson, W. C., Shoham, V., Johnson, S. B., Pope, K. S., Crits-Christoph, P., Baker, M., Johnson, B., Woody, S. R., Sue, S., Beutler, L., Williams, D. A., McCurry, S. (1996). An update on empirically validated therapies. *The Clinical Psychologist, 49,* 5-18.

Chambless, D. L., & Ollendick, T. H. (2001). Empirically supported psychological interventions: Controversies and evidence. *Annual Review of Psychology, 52,* 685-716.

Child and Adolescent Mental Health Division. (2002). Evidence Based Services Committee: Biennial report. Honolulu: Hawaii Department of Health, Child and Adolescent Mental Health Division.

Child and Adolescent Mental Health Division. (2003a). Evidence Based Services Committee: Biennial report. Honolulu: Hawaii Department of Health, Child and Adolescent Mental Health Division.

Child and Adolescent Mental Health Division. (2003b). Evidence Based Services Committee: Coding manual. Honolulu: Hawaii Department of Health, Child and Adolescent Mental Health Division.

Child and Adolescent Mental Health Division. (2004). Annual Evaluation Report: Fiscal Year 2004. Honolulu, HI: Hawaii Department of Health, Child and Adolescent Mental Health Division.

Chorpita, B. F., Daleiden, E. L., and Weisz, J. R. (2005). Identifying and Selecting the Common Elements of Evidence Based Interventions: A Distillation and Matching Model. *Mental Health Services Research,* 5, 5-20.

Chorpita, B.F., Yim, L.M., Donkervoet, J.C., Arensdorf, A., Amundsen, M., McGee, C., Serrano, A., Yates, A., & Morelli, P. (2002). Toward large-scale implementation of empirically supported treatments for children: A review and observations by the Hawaii empirically basis to services task force. *Clinical Psychology: Science and Practice, 9,* 165-190.

Daleiden, E. L., Young, J., Schiffman, J., & Becker, K. (2005). Service planning performance improvement project: IRB proposal 2005. Honolulu, HI: Hawaii Department of Health, Child and Adolescent Mental Health Division.

DeRubeis, R.J., & Crits-Cristoph, P. (1998). Empirically supported individual and group psychological treatment for adult mental disorders. *Journal of Consulting and Clinical Psychology, 66,* 37-52.

Eifert, G.H., Evans, I.M., & McKendrick, V.G. (1990). Matching treatments to client problems not diagnostic labels: A case for paradigmatic behavior therapy. *Journal of Behavior Therapy and Experimental Psychiatry, 21,* 163-172.

Evidence Based Services Committee (2004). *2004 biennial report.* Honolulu, HI: Hawaii Department of Health, Child and Adolescent Mental Health Division.

Kendall, P.C., Chu, B., Gifford, A., Hayes, C., & Nauta, M. (1998). Breathing life into a manual: Flexibility and creativity with manual-based treatments. *Cognitive and Behavioral Practice, 5,* 177-198.

Luborsky, L., Rosenthal, R., Diguer, L. Andrusyna, T. P., Berman, J. S., Levitt, J. T, Seligman, D. A., & Krause, E. D. (2002). The dodo bird verdict is alive and well—mostly. *Clinical Psychology: Science and Practice, 9,* 2-12.

Persons, J.B. (1991). Psychotherapy outcome studies do not accurately represent current models of psychotherapy: A proposed remedy. *American Psychologist, 46,* 99-106.

Rogers, E. (2003). *Diffusion of Innovations, 5th Edition.* New York, NY: Free Press.

Stroul, B. A. and Friedman, R. M. (1986). *A system of care for children and youth with severe emotional disturbances.* Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.

Westen, D., Novotny, C. M. & Thompson-Brenner, H. (2004). The empirical status of empirically supported psychotherapies: Assumptions, findings and reporting in controlled trials. *Psychological Bulletin, 130,* 631-663.

Appendix A: Instructions and Codebook for Service Guidance Review Forms

The instructions and codebook are to be used in conjunction with the CAMHD Service Guidance Review Forms. The codebooks define the various treatment targets and intervention strategies available on the Service Guidance Review Form checklist. For questions regarding these definitions or the use of the form, please contact John Young at johnyoun@hawaii.edu.

Instructions

This coding instrument will be used to examine information contained in CAMHD clients' Mental Health Assessment (MHAs), Coordinated Service Plans (CSPs) and Mental Health Treatment Plans (MHTPs) as part of a performance improvement project. For each client included in this study, documents of each type will be coded. A separate sheet is necessary for each type of document for every case. Instructions that follow should be consistent across domains, but please keep in mind that each report type (MHA, CSP, MHTP) is coded on its own sheet. When you have completed coding for all reports for a given case, please staple all the code sheets for that case together.

At the top section, please indicate your Name, circle your Position within the DOH (either Quality Assurance Specialist, QAS, Mental Health Supervisor, MHS, Research and Evaluation Trainee, RET, or Other) and circle the Condition under which you are coding the materials. Full Access will be the most typical case, where you have information regarding the client's diagnosis, and Blind will apply only to RETs who will code a subsection of reports with information regarding diagnosis being redacted.

Under the Order of Coding section, please circle the order in which you coded materials. Efforts will be made to ensure that case materials are organized in a way that changes the order of presentation to coders. Please be sure to code materials in the order that they are presented, and record this information on the coding sheet.

Under the Report Information section, please write the Client Name, CR Number, Age of Client at Time of Report, Reporter's Credentials, Document Date, the Care Coordinator ID for the Care Coordinator associated with the case, and 5-Axis Diagnosis Information for the case. Reporter's Credentials refers to the academic degree and/or certifications of the preparer of a coded document. For example, if an MHA was completed by a psychiatrist, the information coded would be M.D.

Under Type of Document, please indicate the form of archived report that is being coded.

> Mental Health Assessment (MHA) – client's initial mental health assessment that describes the nature of the client's particular strengths and difficulties
> Coordinated Service Plan (CSP) – recommendations by service procuring agents that determine the scope of a client's treatment
> Mental Health Treatment Plan (MHTP) – service provider's outline of the expected direction of treatment for a specific client

Under Service Format, please note whether services were recommended to be delivered in the following manner (more than one format can be selected):

Individual – Working with youth directly
Group – Working with youth along with other youths receiving services
Parent – Working directly with parents or caretakers, with youth not present
Family – Working with parents or caretakers and youth together. Can include other family members
Teacher – Working with a teacher directly
Other – Another format not specified above; please write description

Please additionally note beneath each circled service format code any information pertaining to the recommended Frequency of service, if known (e.g., 1 visit per week; 2 visits per month).

Under Service Setting, please note the locations in which services were recommended to be administered (more than one setting can be selected):

Home –Working with youth or family members in the youth's home
School –Working with youth or professionals in the youth's educational setting, other than in the context of an IEP/MP meeting
Community – Working with youth or others in the youth's community/neighborhood
Out of Home – Working with the youth or family in a residential facility
Clinic/Office – Working with the youth or family in a clinical office
Other – Another setting not specified above; please write description

Targets

Targets are the strengths and needs being addressed as part of the mental health services for that youth. Please place a mark (X, ✔) to the left of any recommended targets of services. For example, if an MHA indicated that services should focus on the alleviation of depression in the youth, you would mark the box next to "depressed mood" on the code sheet. If a target was recommended for which there is no code, please mark the box next to "other" and describe the target.

A list of treatment targets and definitions follows that is intended to provide a summary of strengths and problem areas that are commonly recommended to be targeted for change during mental health service provision. It is important to note that these problem areas are NOT simply diagnostic descriptions. Please make use of the definitions outlined in this section when considering which targets to code for particular reports.

Definitions of Targets

1. Academic Achievement – Issues related to general level or quality of achievement in an educational or academic context. This commonly includes performance in

coursework, and excludes cognitive-intellectual ability/capacity issues (#13) and specific challenges in learning or achievement (#29).

2. Activity Involvement – Issues related to general engagement and participation in activities. Only code here those activities that are not better described by the particular activity classes of school involvement (#48), peer involvement (#37), or community involvement (#14).
3. Adaptive Behavior/Living Skills – Target develop of skills related to independent living, social functioning, financial management, and self-sufficiency that are not better captured under other codes such as personal hygiene (#40), self-management (#51), social skills (#56), housing/living situation, or occupational functioning/stress.
4. Adjustment to Change – Refers to targeting a youth's global response to a life transition or specific challenge (e.g., change of school, living situation, treatment transition or discharge, etc.).
5. Adult Intercoordination – Target communication and interaction among relevant adults and/or service system workers involved in a child's life. This includes such things as home-school relationships, communication between service providers, treatment team members, transition and discharge preparedness, guardianship issues, etc.
6. Aggression – Verbal and/or physical aggression, or threat thereof, that results in intimidation, physical harm, or property destruction.
7. Anger – Emotional experience or expression of agitation or destructiveness directed at a particular object or individual. Common physical feelings include accelerated heartbeat, muscle tension, quicker breathing, and feeling hot.
8. Anxiety – A general uneasiness that can be characterized by irrational fears, panic, tension, physical symptoms, excessive anxiety, worry, or fear.
9. Assertiveness – The skills or effectiveness of clearly communicating one's wishes. For example, the effectiveness with which a child refuses unreasonable requests from others, expresses his/her rights in a non-aggressive manner, and/or negotiates to get what s/he wants in their relationships with others.
10. Attention Problems – Described by short attention span, difficulty sustaining attention on a consistent basis, and susceptible to distraction by extraneous stimuli.
11. Avoidance – Behaviors aimed at escaping or preventing exposure to a particular situation or stimulus.
12. Caregiver Self-Management/Coping – Attempting to alter a caregiver's management, regulation, or monitoring of their own behavior and emotions
13. Cognitive-Intellectual Functioning – Issues related to cognitive-intellectual ability/capacity and use of those abilities for positive adaptation to the environment. This includes efforts to increase IQ, memory capacity, or abstract problem-solving ability.
14. Community Involvement – Detailed description of amount of involvement in specific community activities within the child's day.

15. Compulsive Behavior – Targeting specific compulsive/excessive responses such as hoarding or trichotillomania
16. Contentment/Enjoyment/Happiness – Refers to issues involving the experience and expression of satisfaction, joy, pleasure, and optimism for the future.
17. Depressed Mood – Behaviors that can be described as persistent sadness, anxiety, or "empty" mood, feelings of hopelessness, guilt, worthlessness, helplessness, decreased energy, fatigue, etc.
18. Eating/Feeding Problems– Knowledge or behaviors involved with the ingestion or consumption of food. May include nutritional awareness, food choice, feeding mechanics (e.g., swallowing, gagging, etc.), and social factors relating with eating situations.
19. Empathy – Identifications with and understanding of another person's situation, feelings, and motives.
20. Enuresis/Encopresis – Enuresis refers to the repeated pattern of voluntarily or involuntarily passing urine into inappropriate places during the day or at night in bed or clothes. Encopresis refers to a repeated pattern of voluntarily or involuntarily passing feces into inappropriate places.
21. Fire Setting – Intentionally igniting fires.
22. Gender Identity Problems – Issues related with a youth's self-concept or self-understanding involving sex roles and social behaviors in relation to their biological sex. This does not address self-concept issues involving sexual orientation, which would be coded as "other."
23. Goal Setting – Targeting the clarification and commitment to future goals (e.g., academic, career, etc.) that are not better characterized under other targets such as self-management (#51) or occupational functioning/stress.
24. Grief – Feelings associated with a loss of contact with a significant person in the youth's environment (e.g., parent, guardian, friend, etc.).
25. Health management – Issues related to the improvement or management of one's health, inclusive of both physical illness and fitness. In addition to dealing with the general development of health oriented behavior and management of health conditions, this target can also focus on exercise or lack of exercise.
26. Housing/Living Situation – Refers to finding or stabilizing an appropriate living situation for a youth.
27. Hyperactivity – Can be described by fidgeting, squirming in seat, inability to remain seated, talking excessively, difficulty engaging in leisure activities quietly, etc.
28. Information Gathering – Focus on service provider learning more about the child and family through assessment, evaluation, or history taking.
29. Learning Disorder, Underachievement – Refers to specific challenges with learning or educational performance that are not better accounted for by cognitive-intellectual functioning (#13) or general academic achievement (#1).

30. Low Self-Esteem – An inability to identify or accept his/her positive traits or talents, and accept compliments. Verbalization of self-disparaging remarks and viewing him or herself in a negative manner.
31. Mania – An inflated self-perception that can be manifested by loud, overly friendly social style that oversteps social boundaries and high energy and restlessness with a reduced need for sleep.
32. Medical Regimen Adherence – Knowledge, attitudes, and behaviors related to regular implementation procedures prescribed by a health care professional. Commonly include lifestyle behaviors (e.g., exercise, nutrition), taking medication, or self-administration of routine assessments (e.g., taking blood samples in a diabetic regimen).
33. Occupational Functioning/Stress – Issues related to career interests, seeking employment, obtaining work permits, job performance, or managing job stress or strain that are not better characterized under other targets (e.g., anxiety).
34. Oppositional/Non-Compliant Behavior – Behaviors that can be described as refusal to follow adult requests or demands or established rules and procedures (e.g., classroom rules, school rules, etc.).
35. Other – Write-in targets with a reasonably interpretable intention that could not be categorized into another target area and appear to be of a low enough base rate to not warrant addition of a new category (e.g., enrollment in private high school, gambling, memory)
36. Parenting Skills – Attempting to modifying a caregiver's strategies for managing child behavior, emotions, or structuring of the caregiving environment.
37. Peer Involvement – A greater involvement in activities with peers. Activities could range from academic tasks to recreational activities while involvement could range from working next to a peer to initiating an activity with a peer.
38. Peer/Sibling Conflict – Peer and/or sibling relationships that are characterized by fighting, bullying, defiance, revenge, taunting, incessant teasing and other inappropriate behaviors.
39. Phobia/Fears – Irrational dread, fear, and avoidance of an object, situation, or activity.
40. Personal Hygiene – Challenges related to self-care and grooming.
41. Positive Family Functioning – Issues related with healthy communication, problem-solving, shared pleasurable activities, physical and emotional support, etc. in the context of a interactions among multiple persons in a family relation, broadly defined.
42. Positive Peer Interaction – Social interaction and communication with peers that are pro-social and appropriate. This differs from peer involvement (#37) in that it focuses on interactional behavior, styles, and intentions, whereas peer involvement targets actual engagement in activities with peers regardless of interactional processes.
43. Positive Thinking/Attitude – This target involves clear, healthy, or optimistic thinking, and involves the absence of distortions or cognitive bias that might lead to maladaptive behavior.

44. Pregnancy Education/Adjustment – Issues related to helping a pregnant youth prepare and adjust to parenthood.
45. Psychosis – Issues related to bizarre thought content (delusions of grandeur, persecution, reference, influence, control, somatic sensations), and/or auditory or visual hallucinations.
46. Runaway – Running away from home or current residential placement for a day or more.
47. Safe Environment – Establishing a safe and secure environment for the youth's development.
48. School Involvement – Detailed description of amount of involvement in specific school activities within the child's scheduled school day.
49. School Refusal/Truancy – Reluctance or refusal to attend school without adult permission for the absence. May be associated with school phobia or fear manifested by frequent somatic complaints associated with attending school or in anticipation of school attendance, or willful avoidance of school in the interest of pursuing other activities.
50. Self-Injurious Behavior – Acts of harm, violence, or aggression directed at oneself.
51. Self-Management/Self-Control – Issues related to management, regulation, and monitoring of one's own behavior.
52. Sexual Misconduct – Issues related with sexual conduct that is defined as inappropriate by the youth's social environment or that includes intrusion upon or violation of the rights of others.
53. Sexual Orientation – Issues related to clarification or management of a youth's sexual orientation that are excluded from the gender identity problems code (#22).
54. Shyness – Social isolation and/or excessive involvement in isolated activities. Extremely limited or no close friendships outside the immediate family members. Excessive shrinking or avoidance of contact with unfamiliar people.
55. Sleep Disturbance – Difficulty getting to or maintaining sleep.
56. Social Skills – Skills for managing interpersonal interactions successfully. Can include body language, verbal tone, assertiveness, and listening skills, among other areas.
57. Speech and Language Problems – Expressive and/or receptive language abilities substantially below expected levels as measured by standardized tests.
58. Substance Abuse/Substance Use – Issues related to the use or misuse of a common, prescribed, or illicit substances for altering mental or emotional experience or functioning.
59. Suicidality – Issues related to recurrent thoughts, gestures, or attempts to end one's life.

60. Traumatic Stress – Issues related to the experience or witnessing of life events involving actual or threatened death or serious injury to which the youth responded with intense fear, helplessness, or horror.
61. Treatment Engagement – The degree to which a family or youth is interested and optimistic about an intervention or plan, such that they act willfully to participate and work toward the success of the plan.
62. Treatment Planning/Framing – Setting or revising treatment plan or structure (including IEPs, CSPs, MPs, MHTPs, etc.)
63. Unclear – Write-in targets when the intention of the respondent could not be coded into another category (e.g., relationship issues not otherwise specified).
64. Willful Misconduct/Delinquency – Persistent failure to comply with rules or expectations in the home, school, or community. Excessive fighting, intimidation of others, cruelty or violence toward people or animals, and/or destruction of property.

Intervention Strategies

Please place a mark (X, ✔) to the left of any recommended intervention strategies. There is no limit to how many may be checked. If strategies were recommended that are not in the following list of definitions, please mark the "other" box and write a description of the strategy used. Please note that "homework" and "in-vivo work" are not specific interventions that can be coded. Instead, the specific focus of any recommended "homework" or "in-vivo" exercises should be coded. For example, if an MHA recommended that a client engage in homework exercises of planning pleasant events, you would code this as "activity scheduling."

Definitions of Intervention Strategies

1. Activity Scheduling - The assignment or request that a child participate in specific activities outside of therapy time, with the goal of promoting or maintaining involvement in satisfying and enriching experiences.
2. Anger Management – Refers to treatment in the family of anger management with no specific practices identified
3. Animal or Plant Assisted Activities – Use of activities incorporating animals or plants as a therapeutic modality.
4. Arousal Reconditioning – Use of classical or operant conditioning procedures to alter the targets of sexual arousal.
5. Art/Music Therapy – Use of expressive activities as a therapeutic modality
6. Assertiveness Training-Exercises or techniques designed to promote the child's ability to be assertive with others, usually involving rehearsal of assertive interactions.

7. Assessment – Focus on service provider learning more about the child and family through evaluation, testing, or observation (that would not qualify as parent or self-monitoring).
8. Behavioral Contracting – Development of a formal agreement specify rules, consequences, and a commitment by the youth and relevant others to honor the content of the agreement
9. Behavior Management – Indication of the use of behavioral techniques or plan with no specific practices identified
10. Biofeedback/ Neurofeedback-Strategies to provide information about physiological activity that is typically below the threshold of perception, often involving the use of specialized equipment.
11. Care Coordination – Coordinating among the service providers to ensure effective communication, receipt of appropriate services, adequate housing, etc.
12. Catharsis-Strategies designed to bring about the release of intense emotions, with the intent to develop mastery of affect and conflict.
13. Cognitive/Coping-Any techniques designed to alter interpretation of events through examination of the child's reported thoughts, typically through the generation and rehearsal of alternative counter-statements. This can sometimes be accompanied by exercises designed to comparatively test the validity of the original thoughts and the alternative thoughts through the gathering or review of relevant information.
14. Commands/Limit Setting-Training for caretakers in how to give directions and commands in such a manner as to increase the likelihood of child compliance.
15. Communication Skills-Training for youth or caretakers in how to communicate more effectively with others to increase consistency and minimize stress. Can include a variety of specific communication strategies (e.g., active listening, "I" statements).
16. Counseling – Refers to counseling sessions with youth or parent with no specific practices identified
17. Crisis Management-Immediate problem solving approaches to handle urgent or dangerous events. This might involve defusing an escalating pattern of behavior and emotions either in person or by telephone, and is typically accompanied by debriefing and follow-up planning.
18. Cultural Training – Education or interaction with culturally important values, rituals, or sites with no specific practices identified.
19. Directed Play-Exercises involving the youth and caretaker playing together in a specific manner to facilitate their improved verbal communication and nonverbal interaction. Can involve the caretaker's imitation and participation in the youth's activity, as well as parent-directed play.
20. Educational Support-Exercises designed to assist the child with specific academic problems, such as homework or study skills. This includes tutoring.

21. Emotional Processing-A program based on an information processing model of emotion that requires activation of emotional memories in conjunction with new and incompatible information about those memories.
22. Exposure-Techniques or exercises that involve direct or imagined experience with a target stimulus, whether performed gradually or suddenly, and with or without the therapist's elaboration or intensification of the meaning of the stimulus.
23. Eye Movement/Tapping-A method in which the youth is guided through a procedure to access and resolve troubling experiences and emotions, while being exposed to a therapeutic visual or tactile stimulus designed to facilitate bilateral brain activity.
24. Family Engagement-The use of skills and strategies to facilitate family or child's positive interest in participation in an intervention.
25. Family Therapy-A set of approaches designed to shift patterns of relationships and interactions within a family, typically involving interaction and exercises with the youth, the caretakers, and sometimes siblings.
26. Family Visit – Structured or unstructured therapeutic visit with one or more family members who is not typically part of the youth's daily ecology during the course of treatment
27. Free Association-Technique for probing the unconscious in which a person recites a running commentary of thoughts and feelings as they occur.
28. Functional Analysis-Arrangement of antecedents and consequences based on a functional understanding of a youth's behavior. This goes beyond straightforward application of other behavioral techniques.
29. Goal Setting – Setting specific goals and developing commitment from youth or family to attempt to achieve those goals (e.g., academic, career, etc.).
30. Guided Imagery-Visualization or guided imaginal techniques for the purpose of mental rehearsal of successful performance. Guided imagery for the purpose of physical relaxation (e.g., picturing calm scenery) is not coded here, but rather coded under relaxation (#60).
31. Ho'Oponopono – Intervention using the techniques of Ho'Oponopono with no specific practices identified
32. Hypnosis-The induction of a trance-like mental state achieved through suggestion.
33. Ignoring or Differential Reinforcement of Other Behavior-The training of parents or others involved in the social ecology of the child to selectively ignore mild target behaviors and selectively attend to alternative behaviors.
34. Informal Supports – Explicitly identifying and working with youth or families to make use of informal supports in their homes and communities (e.g., cultural or faith based groups, neighbors and friends, etc.)
35. Insight Building-Activity designed to help a youth achieve greater self-understanding.

36. Interpretation-Reflective discussion or listening exercises with the child designed to yield therapeutic interpretations. This does not involve targeting specific thoughts and their alternatives, which would be coded as cognitive/coping.
37. Juvenile Sex Offender Treatment – Indication of sex offender treatment with no specific practices identified
38. Legal Assistance/Involvement – Obtaining legal aide for the youth or family or engaging the legal system to provide additional motivation for treatment
39. Line of Sight Supervision-Direct observation of a youth for the purpose of assuring safe and appropriate behavior.
40. Maintenance/Relapse Prevention-Exercises and training designed to consolidate skills already developed and to anticipate future challenges, with the overall goal to minimize the chance that gains will be lost in the future
41. Marital Therapy-Techniques used to improve the quality of the relationship between caregivers.
42. Medication/ Pharmacotherapy-Any use of psychotropic medication to manage emotional, behavioral, or psychiatric symptoms.
43. Mentoring-Pairing with a more senior and experienced individual who serves as a positive role model for the identified youth.
44. Milieu Therapy-A therapeutic approach in residential settings that involves making the environment itself part of the therapeutic program. Often involves a system of privileges and restrictions such as a token or point system.
45. Mindfulness-Exercises designed to facilitate present-focused, non-evaluative observation of experiences as they occur, with a strong emphasis of being "in the moment." This can involve the youth's conscious observation of feelings, thoughts, or situations.
46. Modeling-Demonstration of a desired behavior by a therapist, confederates, peers, or other actors to promote the imitation and subsequent performance of that behavior by the identified youth.
47. Motivational Interviewing-Exercises designed to increase readiness to participate in additional therapeutic activity or programs. These can involve cost-benefit analysis, persuasion, or a variety of other approaches.
48. Natural and Logical Consequences-Training for parents or teachers in (a) allowing youth to experience the negative consequences of poor decisions or unwanted behaviors, or (b) delivering consequences in a manner that is appropriate for the behavior performed by the youth.
49. Other – write-in practices with a reasonably interpretable intention that could not be categorized into another target area and appear to be of a low enough base rate to not warrant addition of a new category (e.g., bibliotherapy)

50. Parent Coping-Exercises or strategies designed to enhance caretakers' ability to deal with stressful situations, inclusive of formal interventions targeting one or more caretaker.
51. Parent-Monitoring-The repeated measurement of some target index by the caretaker.
52. Parent Praise-The training of parents or others involved in the social ecology of the child in the administration of social rewards to promote desired behaviors. This can involve praise, encouragement, affection, or physical proximity.
53. Parenting – Indication of addressing parenting issues with caregiver(s) but no specific practices identified
54. Peer Modeling/Pairing-Pairing with another youth of same or similar age to allow for reciprocal learning or skills practice.
55. Play Therapy-The use of play as a primary strategy in therapeutic activities. This may include the use of play as a strategy for clinical interpretation. Different from Directed Play (#19), which involves a specific focus on modifying parent-child communication. This is also different from play designed specifically to build relationship quality (#59).
56. Problem Solving-Techniques, discussions, or activities designed to bring about solutions to targeted problems, usually with the intention of imparting a skill for how to approach and solve future problems in a similar manner.
57. Psychoeducational-Child-The formal review of information with the child about the development of a problem and its relation to a proposed intervention.
58. Psychoeducational-Parent-The formal review of information with the caretaker(s) about the development of the child's problem and its relation to a proposed intervention. This often involves an emphasis on the caretaker's role in either or both.
59. Relationship/Rapport Building-Strategies in which the immediate aim is to increase the quality of the relationship between the youth and the therapist. Can include play, talking, games, or other activities.
60. Relaxation-Techniques or exercises designed to induce physiological calming, including muscle relaxation, breathing exercises, meditation, and similar activities. Guided imagery exclusively for the purpose of physical relaxation is also coded here.
61. Response Cost-Training parents or teachers how to use a point or token system in which negative behaviors result in the loss of points or tokens for the youth.
62. Response Prevention-Explicit prevention of a maladaptive behavior that typically occurs habitually or in response to emotional or physical discomfort.
63. Self-Monitoring-The repeated measurement of some target index by the child.
64. Self-Reward/Self-Praise-Techniques designed to encourage the youth to self-administer positive consequences contingent on performance of target behaviors.

65. Skill Building-The practice or assignment to practice or participate in activities with the intention of building and promoting talents and competencies (e.g., piano lessons). This category does not include building specific skills codable elsewhere.
66. Social Skills Training-Providing information and feedback to improve interpersonal verbal and non-verbal functioning, which may include direct rehearsal of the skills. If this is paired with peer modeling/pairing (#54), that should be coded as well.
67. Stimulus/Antecedent Control-Strategies to identify specific triggers for problem behaviors and to alter or eliminate those triggers in order to reduce or eliminate the behavior.
68. Supportive Listening-Reflective discussion with the child designed to demonstrate warmth, empathy, and positive regard, without suggesting solutions or alternative interpretations.
69. Tangible Rewards-The training of parents or others involved in the social ecology of the child in the administration of tangible rewards to promote desired behaviors. This can involve tokens, charts, or record keeping, in addition to first-order reinforcers.
70. Therapist Praise/Rewards-The administration of tangible rewards (e.g., candy) or social (e.g., praise) reinforcers by the therapist.
71. Thought Field Therapy-Techniques involving the tapping of various parts of the body in particular sequences or "algorithms" in order to correct unbalanced energies, known as thought fields.
72. Time Out-The training of or the direct use of a technique involving removing the youth from all reinforcement for a specified period of time following the performance of an identified, unwanted behavior.
73. Twelve-step Programming-Any programs that involve the twelve-step model for gaining control over problem behavior, most typically in the context of alcohol and substance use, but can be used to target other behaviors as well.
74. Unclear – Write-in practices when the intention of the respondent could not be coded into another category.

Please provide any Comments related to your experience of difficulty or irregularity with coding, both generally in terms of the coding system and specifically in terms of an individual case. All comments placed in this section will be read and may be extremely useful in terms of enhancing this process for continued usage.

Appendix B: Service Guidance Review Form

Service Guidance Review Form

Instructions: For each case and type of planning document considered, please fill out a separate sheet including the following information. Redacted reports need not include client information beyond CR#.

Coder Information:

Name:	Position: **CAMHD Employee** **GA**

Report Information:

Client Name:	CR #:	Client age at time of report: ____ years _____ months
Reporter's Credentials:	Document Date:	Care Coordinator ID:
Diagnosis Information: Axis I: Axis II: Axis III: Axis IV: Axis V:		

Type of Document Being Coded (circle only one):

Mental Health Assessment (MHA)	Coordinated Service Plan (CSP)	Mental Health Treatment Plan (MHTP)

Recommended Service Format and Frequency (circle any that apply and, if known, indicate frequency below):

Individual	Group	Parent	Family	Teacher	Other: _____
____ visit(s) per _____	____ visit(s) per _____	____ visit(s) per _____	____ visit(s) per _____	____ visit(s) per _____	____ visit(s) per _____

Recommended Service Setting (circle any that apply):

Home School Community Out of Home Clinic/Office Other: _____

Suggested Targets of Services:

Academic/Intellectual		**Internalizing**			Positive Peer Interaction		Sleep Disturbance
	Academic Achievement		Activity Involvement		Social Skills		Treatment Engagement
	Cognitive-Intellectual Functioning		Anxiety	**Other**			Treatment Planning/ Framing
	Learning Disorder, Underachievement		Avoidance		Adaptive Behavior/Living Skills		Unclear
	School Involvement		Compulsive Behavior		Adjustment to Change		Other
	School Refusal/Truancy		Depressed Mood		Community Involvement		Other
	Speech and Language Problems		Enuresis, Encopresis		Contentment, Enjoyment, Happiness		Other
Adult Targets			Grief		Eating, Feeding Problems		
	Adult Inter-coordination		Low Self-Esteem		Gender Identity Problems		
	Caregiver Self-Management/ Coping		Phobia/Fears		Goal Setting		
	Parenting Skills		Shyness		Housing/Living Situation		
Externalizing			Suicidality		Information Gathering		
	Aggression		Traumatic Stress		Mania		
	Anger	**Self-Care**			Occupational Functioning/Stress		
	Attention Problems		Health Management		Positive Family Functioning		
	Fire Setting		Medical Regimen Adherence		Positive Thinking/Attitude		
	Hyperactivity		Personal Hygiene		Pregnancy Education/ Adjustment		
	Oppositional/Non-Compliant Behavior	**Social**			Psychosis		
	Runaway		Assertiveness		Safe Environment		
	Sexual Misconduct		Empathy		Self-Injurious Behavior		
	Substance Use		Peer Involvement		Self-Management/Self-Control		
	Willful Misconduct, Delinquency		Peer/Sibling Conflict		Sexual Orientation		

Practice Elements of Suggested Interventions:

	Activity Scheduling		Counseling		Ho'Oponopono		Modeling		Response Prevention
	Anger Management		Crisis Management		Hypnosis		Motivational Interviewing		Self-Monitoring
	Animal or Plant Assisted Activities		Cultural Training		Ignoring or DRO		Natural and Logical Consequences		Self-Reward/ Self-Praise
	Arousal Reconditioning		Directed Play		Informal Supports		Parent Coping		Skill Building
	Art/Music Therapy		Educational Support		Insight Building		Parent-Monitoring		Social Skills Training
	Assertiveness Training		Emotional Processing		Interpretation		Parent Praise		Stimulus or Antecedent Control
	Assessment		Exposure		Juvenile Sex Offender Treatment		Parenting		Supportive Listening
	Behavioral Contracting		Eye Movement, Tapping		Legal Assistance/ Involvement		Peer Modeling or Pairing		Tangible Rewards
	Behavior Management		Family Engagement		Line of Sight Supervision		Play Therapy		Therapist Praise/Rewards
	Biofeedback, Neurofeedback		Family Therapy		Maintenance or Relapse Prevention		Problem Solving		Thought Field Therapy
	Care Coordination		Family Visit		Marital Therapy		Psychoeducation, Child		Time Out
	Catharsis		Free Association		Medication/Pharm-acotherapy		Psychoeducation,Parent		Twelve-step Programming
	Cognitive/Coping		Functional Analysis		Mentoring		Relationship or Rapport Building		Unclear
	Commands/ Limit Setting		Goal Setting		Milieu Therapy		Relaxation		Other:
	Communication Skills		Guided Imagery		Mindfulness		Response Cost		Other:

Comments (***please mention any difficulty or irregularity with coding here; attach additional sheets if necessary***)**:**

Appendix C: CAMHD Notice of Privacy Practices

Child and Adolescent Mental Health Division

Notice of Privacy Practices

Effective April 14, 2003

Child and Adolescent Mental Health Division
("CAMHD")

THIS NOTICE EXPLAINS HOW MEDICAL INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED. IT ALSO EXPLAINS HOW YOU CAN ACCESS THIS INFORMATION. PLEASE READ IT CAREFULLY.

Understanding Your Child's Protected Health Information:

CAMHD staff and doctors take notes each time your child visits them. They write down what they think is your child's condition and how they plan to care for them. Your child's health record has information that can identify him or her. This kind of information is known as "Protected Health Information." Your child's name and Social Security number are types of PHI.

If you know what is in the health record you can better protect your child's Protected Health Information ("PHI"). You can also ask how PHI will be used. You can decide if PHI should be disclosed. You can make sure that the health record is accurate.

Our Duties:

CAMHD must:

- Protect the privacy of PHI.
- Tell you about our legal duties.
- Tell you about our privacy practices. You have the right to know how CAMHD uses PHI.
- Abide by this notice.

CAMHD can change its practices at any time. We will mail you a copy of any new notice within 60 days.

CAMHD will ask for your consent before disclosing PHI. CAMHD can disclose PHI without your permission. But any release of PHI will follow the law, as explained in this notice.

Your Child's Health Information Rights:

CAMHD owns your child's health record. However, the information in the record belongs to
your child. On behalf of your child you have the right to:

- View or get paper copies of PHI.
- Decide how we send PHI to you. For example, CAMHD usually sends information by mail. You may ask to get PHI by other means, such as fax. You may also ask us to send PHI to another address.
- Ask to limit the use and disclosure of PHI. CAMHD is not required by law to agree to every request.
- Ask for corrections to your child's health record.
- Get an accounting of PHI disclosures.
- Change your mind about allowing use or disclosures of PHI. This does not apply to disclosures that have already happened.

Information that does not identify your child is used for:

- Medical and mental health research.
- Planning and improving services.
- Improving health care.

Examples of Disclosures for Treatment, Payment, and Health Operations: CAMHD sometimes has to share PHI with other agencies to provide services. CAMHD will only share the minimum necessary PHI with them. We will also require them to protect the PHI they receive.

CAMHD will use and share PHI for the following purposes:

Treatment. For example: A CAMHD professional notes your child's and the treatment team's expectations in the health record. A doctor logs the actions taken and his or her observations. The care coordinator can review your child's record later to see if those goals were met.

Payment. For example: A provider sends a bill to CAMHD. The bill or accompanying materials may contain PHI.

Regular Health Operations. For example: CAMHD staff uses PHI to evaluate treatment outcomes. This helps CAMHD to improve our services.

Other Uses or Disclosures (Permission not Needed):

Business Associates. For example: CAMHD provides some of its services by contract. We may hire an auditor to review financial records. Those records may contain PHI about your child.

Health Oversight. CAMHD may share PHI with certain government oversight agencies. The U.S. Department of Health and Human Services is an example of such an agency.

Law Enforcement. CAMHD may share PHI for law enforcement purposes.

Coroners, Medical Examiners and Funeral Directors. CAMHD may share PHI with people who need it to do this type of work.

Organ Donation and Disease Registers. CAMHD may share PHI with authorized organ donation and transplantation organizations.

Research. CAMHD may share information with researchers under certain conditions. An Institutional Review Board (IRB) must approve the research project. The IRB will also enforce rules that require researchers to keep PHI private.

Public Health. CAMHD may have to disclose PHI to prevent or control disease, injury, or disability. CAMHD may share PHI with public health authorities for those reasons.

Correctional institution. If your child is at a correctional facility, CAMHD can provide PHI to the facility. We will share PHI with the facility when needed to protect the health and safety of your child and others.

Victims of Abuse (including Child Abuse), Neglect or Domestic Violence. CAMHD is required to report all suspected cases of abuse or neglect. CAMHD must contact the Police or Child Protective Services to make a report. These reports may contain PHI.

Specialized Government Functions. CAMHD may disclose PHI for national security or intelligence purposes. We may disclose PHI to protective services for the President. It may disclose PHI to others as required by law.

Judicial and Administrative Hearings. CAMHD may share PHI in judicial or administrative hearings. CAMHD will only share PHI after being served with an order of a court or administrative tribunal. CAMHD may also share PHI to respond to lawful processes. Subpoenas are a common type of lawful process.

Other Government Agencies. CAMHD may share PHI with other government agencies if necessary to verify that your child is entitled to other benefits or services.

Family Educational Rights and Privacy Act (FERPA):

Your child's records may also be considered "education records." CAMHD will only disclose information in your child's education records as allowed by FERPA regulations. The Department of Education provides you with your child's FERPA notice.

For More Information or to Report a Problem:

You may contact us if you have other questions or want more information. Please call the CAMHD Privacy Coordinator at (808) 733-8370. You may also write to:

CAMHD Privacy Coordinator
3627 Kilauea Avenue, Suite 101
Honolulu, HI 96816

You can also file a complaint with the U.S. Department of Health and Human Services. You may contact them at:

Office of Civil Rights
Medical Privacy, Complaint Division
U.S. Department of Health and Human Services
200 Independence Avenue, S.W., HHH Bldg., Room 509H
Washington, DC 20201
Phone: (866) 627-7748
TTY: (886) 788-4989
E-mail: www.hhs.gov/ocr

No one will face retaliation for filing a complaint.

My signature below indicates that I have been provided with a copy of the notice of privacy practices.

Name: _____ Child's Name: _____

Signature: _____ Signature: _____

Date: _____ Date: _____

Relationship to child:

_____

Effective Date: April 14, 2003.
Distribution: Original to CAMHD.
Copy to Parent/Guardian.
6/03